

Wellness & Quality of Life Survey

Name: _____

Date: _____

Please circle the number that best describes your **CURRENT** experience.

1. Physical State

How often do you experience the following symptoms?

	Never	Rarely	Occasionally	Regularly	Constantly
1. Physical Pain (neck/back ache, sore arms/legs, etc.)	1	2	3	4	5
2. Feeling of tension, stiffness or lack of flexibility	1	2	3	4	5
3. Fatigue or low energy	1	2	3	4	5
4. Colds and flu	1	2	3	4	5
5. Headaches (of any kind)	1	2	3	4	5
6. Heartburn or indigestion	1	2	3	4	5
7. Nausea or constipation	1	2	3	4	5
8. Menstrual discomfort	1	2	3	4	5
9. Dizziness or light-headedness	1	2	3	4	5
10. Accidents or near accidents or falling or tripping	1	2	3	4	5
11. Ease of recovery from injury	1	2	3	4	5
12. Restricted or shallow breathing	1	2	3	4	5

II. Mental/Emotional State

Rate the following questions with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. If pain is present, how distressed are you about it?	1	2	3	4	5
2. Presence of negative or critical feelings about yourself.	1	2	3	4	5
3. Experience of moodiness, temper or anger outbursts	1	2	3	4	5
4. Experience of depression or lack of interest	1	2	3	4	5
5. Over reacting to life's stresses	1	2	3	4	5
6. Being overly worried about small things.	1	2	3	4	5
7. Experience of vague fears or anxiety	1	2	3	4	5
8. Difficulty thinking or concentrating or indecisiveness	1	2	3	4	5
9. Difficulty falling or staying asleep	1	2	3	4	5
10. Experience of recurring thoughts or dreams	1	2	3	4	5

III. Stress Evaluation

Evaluate your stress relative to the following:

	Never	Slight	Moderate	Considerable	Extensive
1. Family	1	2	3	4	5
2. Significant Other	1	2	3	4	5
3. Physical Health	1	2	3	4	5
4. Finances	1	2	3	4	5
5. Sex Life	1	2	3	4	5
6. Work or School	1	2	3	4	5
7. Coping with daily problems.	1	2	3	4	5

IV. Life Enjoyment

Rate the following statements with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. Openness to guidance from your "inner voice/feelings"	1	2	3	4	5
2. Experience of peace, relaxation, ease or well-being	1	2	3	4	5
3. Presence of positive feelings about yourself	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (i.e., diet, fitness, etc.)	1	2	3	4	5
5. Feeling of being open, aware and connected when relating to others	1	2	3	4	5
6. Level of confidence in your ability to deal with adversity	1	2	3	4	5
7. Level of compassion for and acceptance of others	1	2	3	4	5
8. Experience feelings of joy or happiness	1	2	3	4	5
9. Experiencing gratitude	1	2	3	4	5
10. Level of satisfaction with your sex life	1	2	3	4	5
11. Satisfaction with the level of recreation in your life	1	2	3	4	5
12. Time devoted to things you enjoy	1	2	3	4	5

V. Overall Quality of Life

Evaluate your feelings relative to your quality of life:

	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Delighted
1. Your personal life	1	2	3	4	5
2. Your wife/husband or "significant other"	1	2	3	4	5
3. Your romantic life	1	2	3	4	5
4. Your job	1	2	3	4	5
5. Your co-workers	1	2	3	4	5
6. The actual work you do	1	2	3	4	5
7. The handling of problems in your life	1	2	3	4	5
8. What you are actually accomplishing in your life	1	2	3	4	5
9. Your physical appearance - the way you look	1	2	3	4	5
10. Your ability to adapt to change in your life	1	2	3	4	5
11. Overall contentment with your life.	1	2	3	4	5